NOTICE OF PUBLICATION BAN

In the College of Physicians and Surgeons of Ontario and Dr. Paul Maxwell Irwin, this is notice that the Discipline Committee ordered that there shall be a ban on publication of the names and any information that could disclose the identity of patients referred to orally or in the exhibits filed at the hearing, under subsection 45(3) of the Health Professions Procedural Code (the "Code"), which is Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

Subsection 93(1) of the Code, which is concerned with failure to comply with these orders, reads:

> Every person who contravenes an order made under … section 45… is guilty of an offence and on conviction is liable,
>
> (a) in the case of an individual to a fine of not more than $25,000 for a first offence and not more than $50,000 for a second or subsequent offence; or
>
> (b) in the case of a corporation to a fine of not more than $50,000 for a first offence and not more than $200,000 for a second or subsequent offence.

Indexed as: Ontario (College of Physicians and Surgeons of Ontario) v. Irwin, 2018 ONCPSD 36

THE DISCIPLINE COMMITTEE OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

IN THE MATTER OF a Hearing directed by the Inquiries, Complaints and Reports Committee of the College of Physicians and Surgeons of Ontario pursuant to Section 26(1) of the Health Professions Procedural Code being Schedule 2 of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended.

B E T W E E N:

THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

- and -

DR. PAUL MAXWELL IRWIN

PANEL MEMBERS: **DR. M. DAVIE (CHAIR)**
MR. M. KANJI
DR. P. POLDRE
MR. J. LANGS
DR. P. GARFINKEL

COUNSEL FOR THE COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO:

MS V. WHITE

COUNSEL FOR DR. IRWIN:

MR. J. MUTTER

INDEPENDENT COUNSEL FOR THE DISCIPLINE COMMITTEE:

MR. R. COSMAN

Hearing Date: May 30, 2018
Decision Date: May 30, 2018
Release of Written Reasons: July 20, 2018

PUBLICATION BAN

DECISION AND REASONS FOR DECISION

The Discipline Committee (the "Committee") of the College of Physicians and Surgeons of Ontario heard this matter at Toronto on May 30, 2018. At the conclusion of the hearing, the Committee released a written order stating its finding that the member committed an act of professional misconduct, and setting out the Committee's penalty and costs order, with written reasons to follow.

THE ALLEGATIONS

The Notice of Hearing alleged that Dr. Paul Maxwell Irwin committed an act of professional misconduct:

1. under paragraph 1(1)2 of Ontario Regulation 856/93 made under the Medicine Act, 1991 ("O. Reg. 856/93"), in that he has failed to maintain the standard of practice of the profession; and

2. under paragraph 1(1)33 of O. Reg. 856/93, in that he has engaged in an act or omission relevant to the practice of medicine that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional.

The Notice of Hearing also alleged that Dr. Irwin is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code (the Code), which is Schedule 2 to the *Regulated Health Professions Act, 1991*.

RESPONSE TO THE ALLEGATIONS

Dr. Irwin admitted to the allegation 1 in the Notice of Hearing, that he has failed to maintain the standard of practice of the profession. He also admitted to the allegation of incompetence. Counsel for the College withdrew allegation 2 in the Notice of Hearing.

THE FACTS

The following facts were set out in the Agreed Statement of Facts and Admission, which was filed as an exhibit at the hearing and presented to the Committee:

PART I – FACTS

BACKGROUND

1. Dr. Irwin is a 58-year-old physician with a specialization in general surgery. He graduated from Queen's University in 1986 and has had an independent practice certificate in Ontario since 1989.

Cornwall Community Hospital Investigation

2. In 2014, after concerns regarding Dr. Irwin's clinical practice were raised by staff at the Cornwall Community Hospital, the hospital commenced an external review of his surgical care of patients. The review, which concluded in 2015, found serious quality of care issues. This resulted in a recommendation from the Medical Advisory Committee that Dr. Irwin should only have his privileges at the hospital renewed if his practice was subject to a graduated return to practice under clinical supervision, and if he completed a six-month residency-type retraining program at a Canadian university centre in a surgical program approved by the hospital.

3. While Dr. Irwin accepted the recommendations of the hospital's Medical Advisory Committee for a graduated return to practice under clinical supervision, he challenged the requirement for residency-type retraining. In its decision dated March 30, 2016, the hospital's Board of Directors upheld the requirement for the residency-type training as a condition of his re-appointment. A copy of the Reasons for Decision of the Cornwall Community Hospital Board of Directors regarding Dr. Irwin dated March 30, 2016 are attached at Tab 1 [to the Agreed Statement of Facts and Admission].

4. The College commenced an investigation in April 2015 based upon the information it had received from the Cornwall Community Hospital. On May 4, 2016, the College retained Dr. Faiz A. Daudi to review Dr. Irwin's surgical practice at the hospital. His report for the College dated June 15, 2016 is attached at Tab 2 [to the Agreed Statement of Facts and Admission. His addendum dated November 14, 2016 is attached at Tab 3 [to the Agreed Statement of Facts and Admission].

5. Dr. Daudi reviewed a total of 36 patient charts and found that Dr. Irwin fell below the standard of care in his care of 12 patients. He found "substantial deficits" in Dr. Irwin's knowledge and judgment and noted that he was "extremely concerned with the patterns of practice" he observed. Of the 24 charts that he found did meet the standard, Dr. Daudi noted that a significant number had minor issues such as violations of hospital booking policy and missing dictations.

6. Among the issues identified by Dr. Daudi were the following:

    1. Incomplete medical records. Missing operative reports, missing discharge summaries or combined admission notes and discharge summaries usually indicating that these were not recorded contemporaneously.
    2. Unacceptable use of slang or colloquial terms in the medical record.
    3. Low threshold of operation. A number of cases were hastily taken to the operating room and would have benefited from more extensive preoperative work-up, further imaging and/or referral to colleagues experienced in alternative techniques.
    4. Multiple instances of incidental appendectomies and oophorectomies. Incidental appendectomies were historically practiced but are rarely indicated in this era of advanced imaging and diagnostics. The frequency of incidental appendectomy was disconcerting in a small sample size of 36 cases and in one of the

cases led to an appendiceal stump leak - this was significant in the patient's demise.

5. Use of Demerol (meperidine). This medication has been removed from almost all hospital formularies and the indication for the medication is extremely limited. Dr. Irwin prescribed this medication in cases where better alternatives exist.
6. Usage of antibiotics. Best Practices in General Surgery (BRIGS) has an Ontario based website that details optimal usage of antibiotics. Dr. Irwin's practice is at significant variance from the norm.
7. Use of mesh in a potentially contaminated field. Use of polypropylene mesh is contraindicated in a field with open bowel. These cases reflect either a knowledge deficit or a cavalier attitude towards patient care.

Patient A

7. On July 17, 2014, the College received a complaint from Patient A, who had attended at the Cornwall Community Hospital emergency department on several occasions in 2013 and 2014 in relation to concerns of lower abdominal pain and difficulty with bowel movements.

8. Dr. Irwin saw Patient A several times in 2013 and in the beginning of 2014 performed surgery to detach the damaged bowel. Several days later, Patient A developed abdominal pain and later had to undergo additional surgery which was performed by another physician.

9. In her complaint to the College, Patient A indicated that although Dr. Irwin was in charge of her care while she was in hospital, he failed to properly communicate with her and her family about her care. She said he visited her late in the evenings when she was on medication and did not answer her family’s questions or keep them informed.

10. The College retained Dr. Jeffrey Shum to provide an opinion on Dr. Irwin's care of Patient A. In his report Dr. Shum opined that Dr. Irwin's care of the patient fell below standard and demonstrated a lack of knowledge and judgment:

> It is my opinion that Dr. Irwin did not meet the standard of practice in the care of Patient A... in that he failed to adequately justify the patient's need for colon and ovarian surgery. He failed to disclose to the patient that she had both ovaries in situ identified on preoperative imaging and he failed to sufficiently document that he had informed, discussed and ensured that the patient had a reasonable understanding of her medical and surgical management.
>
> ...
>
> In my opinion, Dr. Irwin demonstrated a lack of knowledge and judgment in that he did not further investigate the patient's abdominal pain and constipation before embarking on surgery. I believe her complaints of difficulty "going to the bathroom" and being chronically constipated suggested a functional issue that required further studies...None of these investigations were done.
>
> I also believe that he failed to adequately investigate whether the right ovarian cyst was responsible for any of Patient A's symptoms. At the minimum, he should have sought the opinion from a gynecologist prior to consenting her for an oophorectomy, especially as the CT showed both ovaries, one of which was documented to be normal. Dr. Irwin failed to display adequate judgment when he identified both ovaries intra-operatively and then proceeded to resect them. I have found no evidence in the documentation aside from Dr. Irwin's own view that the patient requested to have both ovaries removed. Despite the patient's signed consent for the removal of one ovary, I do not believe that she was fully aware that the recommendation was for interval follow-up as per the radiologist. Prophylactic bilateral oophorectomies in premenopausal women have been associated with premature death, cardiovascular disease, cognitive decline and osteoporosis...All of these facts lead me to believe that her bilateral salpingo-oophorectomy was not justified.

> In my opinion, Dr. Irwin's clinical practice in this case subjected the patient to colon and ovarian surgery that may not have been entirely necessary and that has resulted in complications and subsequent harm.

A copy of Dr. Shum's report dated February 26, 2015 is attached at Tab 4 [to the Agreed Statement of Facts and Admission].

11. Dr. Irwin responded to Dr. Shum's report stating that his approach to diverticular disease is non-operative, but that in his clinical judgment the patient had more than simple diverticular changes. With respect to the bilateral oophorectomy Dr. Irwin maintained that the patient consented and intended to have any remaining ovaries removed, and that the patient was peri-menopausal, thus reducing the potential risks of a bilateral salpingo-oophorectomy. Dr. Irwin acknowledged his deficiencies in documentation.

12. Dr. Shum reviewed Dr. Irwin's response, which did not change his opinion. He noted that the response did not substantiate Dr. Irwin's belief that the patient suffered from complicated diverticular disease. Nor was there any documentation of a discussion with Patient A confirming the clear radiologic evidence that she had two ovaries, or that she understood the risks, benefits and expectations of bilateral oophorectomies. He also expressed concern that Dr. Irwin's comments reflected a lack of acknowledgement and lack of insight that an anastomatic leak was the cause of Patient A's peritonitis and sepsis. A copy of Dr. Shum's addendum dated January 26, 2016 is attached at Tab 5 [to the Agreed Statement of Facts and Admission].

Out-of-Hospital Premises Inspection Investigation

13. In addition to his hospital practice, Dr. Irwin also worked at the Reimer Clinic in Ottawa where he performed endoscopies and administered sedation.

14. On December 11, 2015, the College's Out-of-Hospital Premises Inspection Program conducted an inspection at the Reimer Clinic. During the inspection, Dr. Reena Bhargava, the physician assessor, observed Dr. Irwin performing gastroscopies and colonoscopies and had concerns with his technique and skill. The Physician Observational Component reports regarding Dr. Irwin prepared by Dr. Bhargava are attached at Tab 6 [to the Agreed Statement of Facts and Admission].

15. On December 18, 2015, the Premises Inspection Committee issued a Fail to the Reimer Clinic where patient safety issues had been revealed. The Committee had serious concerns regarding the quality of care that Dr. Irwin provided to his patients and referred the matter to the Inquiries, Complaints and Reports Committee.

16. The College retained Dr. Bhargava to provide an opinion on Dr. Irwin's care of patients at the Reimer Clinic. On July 6, 2016, the College received Dr. Bhargava's report which was based on a review of 10 patient charts and direct observation of two endoscopic procedures. With respect to the 10 charts, she concluded that Dr. Irwin demonstrated a lack of knowledge, skill or judgment in his care of eight patients, and failed to meet the standard of care in three patients. With respect to the two patients observed, she concluded that Dr. Irwin has several deficiencies in his skills. Dr. Bhargava's report is attached at Tab 7 [to the Agreed Statement of Facts and Admission].

17. In her report Dr. Bhargava opines that:

    1. Standard of care:

    Dr. Irwin does at times fail to meet the standard of care in terms of his charting and documentation. Many of the charts were incomplete. The flow of the chart does not follow any organized format. Some charts were missing consult notes while others were missing operative and follow up notes. Other charts have duplicate procedure notes. The two notes for the same procedure are significantly different. Dr. Irwin was able to provide

some missing documentation. However, it is difficult to assess notes that have been dictated retroactively after an inspection.

The notes in the chart have numerous grammatical errors, which makes it difficult to interpret the content.

Dr. Irwin further fails to keep up to date regarding current endoscopic guidelines. Screening, surveillance and follow up of abnormal pathology should follow some formal guidelines.

2. Lack of knowledge, skill and judgment:

Dr. Irwin does display lack of judgment, skill and knowledge. He needs to keep up to date regarding current endoscopic guidelines. Screening, surveillance and follow up of abnormal pathology should follow some formal guidelines. For example, recommended guidelines for the surveillance of low grade dysplasia and Barrett's esophagus were not followed.

In patients with poor bowel preparation, and inadequate visualization, additional testing or a repeat colonoscopy with more aggressive bowel preparation should have been offered.

3. Harm or injury:

In reviewing Dr. Irwin's charts, it does not seem that the patients are at an increased risk of harm or injury. Documentation and organization is the main deficiency. However, on observation I was concerned about Dr. Irwin's endoscopic proficiency. I noted several deficiencies in his skills. With his current lack of endoscopic skills, he may potentially place patients at risk by missing pathology and increasing the risk of complications.

PART II – ADMISSION

18. Dr. Irwin admits the facts in paragraphs 1 - 17 above and admits that, based on these facts, he:

    (a) has failed to maintain the standard of practice of the profession under paragraph 1(1)2 of Ontario Regulation 856/93 made under the *Medicine Act, 1991* ("O/Reg. 856/93"); and

    (b) is incompetent as defined by subsection 52(1) of the Health Professions Procedural Code.

FINDING

The Committee accepted as correct all of the facts set out in the Agreed Statement of Facts and Admission. Having regard to these facts, the Committee accepted Dr. Irwin's admission and found that he committed an act of professional misconduct, in that he has failed to maintain the standard of practice of the profession. The Committee also found that Dr. Irwin is incompetent.

AGREED STATEMENT OF FACTS ON PENALTY

The following facts were set out in the Agreed Statement of Facts on Penalty, which was filed as an exhibit at the hearing and presented to the Committee:

Breach of ICRC Order Restricting Dr. Irwin's Practice

1. On February 14, 2017, the ICRC ordered and directed the Registrar to impose terms, conditions and limitations on Dr. Irwin's certificate of registration restricting his practice to providing small surgical procedures requiring local anaesthesia and surgical consultations (the "Original Order"). It also required that he practice with a clinical supervisor who will review a minimum of 20 charts per month. A copy of

the Original Order is attached at Tab 1 [to the Agreed Statement of Facts on Penalty].

2. On December 12, 2017, the ICRC amended the terms of the Original Order, increasing the frequency and intensity of supervision based on information received by the College (the "Amended Order"). A copy of the Amended Order is attached at Tab 2 [to the Agreed Statement of Facts on Penalty].

3. Pursuant to the Original Order and the Amended Order, Dr. Irwin was required to provide the College with the addresses of all his practice locations. Dr. Irwin did not advise the College that, in addition to practising at clinics in Ottawa and Akwesasne, he had a "home practice" which involved visiting approximately 10 patients in their home.

4. Some of the care provided by Dr. Irwin to patients in Akwesasne and in the home visits exceeded the restrictions on his scope of practice. There is no evidence this care was otherwise inappropriate or below standard.

Monitoring reports

5. Since March of 2017, Dr. Irwin's practice has been subject to monitoring by Dr. Bruce Gay. A copy of his reports are attached as follows:

- May 23, 2017 Report attached at Tab 3[to the Agreed Statement of Facts on Penalty];
- July 31, 2017 Report attached at Tab 4 [to the Agreed Statement of Facts on Penalty];
- October 15, 2017 Report attached at Tab 5 [to the Agreed Statement of Facts on Penalty] ;
- November 25, 2017 Report attached at Tab 6 [to the Agreed Statement of Facts on Penalty];

- January 12, 2018 Report attached at Tab 7 [to the Agreed Statement of Facts on Penalty];
- February 26, 2018 report attached at Tab 8 [to the Agreed Statement of Facts on Penalty];
- March 19, 2018 Report attached at Tab 9 [to the Agreed Statement of Facts on Penalty];
- April 22, 2018 Report attached at Tab 10 [to the Agreed Statement of Facts on Penalty]

Past History

6. In January of 2005, the College received a complaint in relation to Dr. Irwin's care of a patient who died following surgery he provided for resection of a cancerous tumour. The Complaints Committee noted that there was no record of Dr. Irwin performing a complete clinical examination of his elderly patient before the operation and that a thorough pre-operative assessment of the lesion should have been done. The Committee cautioned Dr. Irwin to ensure that he conducts a complete and thorough evaluation of patients pre-operatively, so that he can obtain properly informed consent from the patient before proceeding with surgery. A copy of the decision of the Complaints Committee of November 2005 is attached at Tab 11 [to the Agreed Statement of Facts on Penalty].

7. In January 2011, the College received a complaint about the care provided to a patient who underwent excision of a neck lesion and supraclavicular nodes at the Hospital in 2010. The complainant alleged that Dr. Irwin only obtained his consent for a biopsy of a lesion and excised the mass without consent.

8. The Committee found that there was considerable confusion in the clinical record regarding what consent was provided by the patient, and that Dr. Irwin didn't document the consent discussion until after the surgical procedure had been performed. It also expressed concern that Dr. Irwin's dictation of his operative note was not done until two months after the procedure and after the patient had

complained to the College. Further, the Committee found that Dr. Irwin's operative note had virtually no detail.

9. The Committee issued a written caution to Dr. Irwin on his poor consent process in the case, including his documentation of that process, and on his failure to ensure a timely dictation of his operative note. In addition, the Committee required that Dr. Irwin complete a specified continuing education or remediation program involving the following:

- A course on medical ethics and informed consent;
- Educational sessions with a preceptor on charting and record-keeping; and
- A reassessment.

A copy of the decision of the ICRC dated May 13, 2011 is attached at Tab 12 [to the Agreed Statement of Facts on Penalty].

10. In November of 2014, the College received a patient complaint regarding the care provided to her by Dr. Irwin in 1999 when he performed a gastroscopy, colonoscopy and incisional hernia repair at the Hospital. Following the procedure, she developed sepsis and other complications.

11. An expert opinion obtained by the College found Dr. Irwin's care met the standard and did not demonstrate a lack of knowledge, skill or judgment. However, the ICRC concluded that Dr. Irwin did not meet the standard with respect to his decision to discharge the patient when there was evidence that clearly demonstrated a wound infection following the surgery. The Committee found that Dr. Irwin should have diagnosed a wound infection and that his discharge note indicating that there were no signs of wound infection and her white blood cell count was normal was inaccurate. The Committee issued advice to Dr. Irwin with respect to his postoperative wound management and assessment before discharge, particularly in patients with fever and elevated white blood count. A copy of the

ICRC decision of January 20, 2017 is attached at Tab 13 [to the Agreed Statement of Facts on Penalty].

12. In March of 2015 the College received a complaint from a patient in relation to care he received from Dr. Irwin at the Hospital in 2012 when Dr. Irwin performed an elective anterior resection of his colon for diverticulitis. After the surgery, he developed sepsis and Dr. Irwin found an anastomotic leak and created a colostomy. Further complications arose thereafter.

13. An expert opinion obtained by the College found Dr. Irwin's care met the standard and did not demonstrate a lack of knowledge, skill or judgment, but did note that Dr. Irwin's operating notes lacked detail. The ICRC agreed that Dr. Irwin's documentation in the operative note lacked sufficient details, including details of the anastomosis and the consent discussion. It also concluded that there was an excessive delay in bringing the complainant back to the OR when he began to experience complications, particularly as he was high risk and should have been followed closely.

14. The Committee issued advice to Dr. Irwin to:

- Document thoroughly in the OR note;
- Document the details of his consent discussion with patients; and
  Ensure closer post-operative follow-up of high-risk patients, and noted that in this case there was excessive delay in returning the patient to the OR when the patient had concerning clinical signs of complication.

A copy of the ICRC decision dated January 20, 2017 is attached at Tab 14 [to the Agreed Statement of Facts on Penalty].

PENALTY AND REASONS FOR PENALTY

Counsel for the College and counsel for Dr. Irwin made a joint submission as to an appropriate penalty and costs order. The proposed order included a five-month suspension, a reprimand, and the imposition of terms, conditions and limitations on Dr. Irwin's certificate of registration, including: that his practice continue to be limited to small surgical procedures, involving local anesthetics, and surgical consults; that Dr. Irwin retain a College approved clinical supervisor for at least six months with regular chart reviews, face-to-face meetings, and an individualized education plan; and that Dr. Irwin's practice be reassessed by a College-appointed assessor within six months after completing supervision. Pursuant to the proposed order, Dr. Irwin is also required to apply to the College for any change in scope of his practice and co-operate with unannounced assessments of his practice. The proposed order also requires that Dr. Irwin pay to the College part of the costs of this hearing.

In considering the joint submission on penalty and costs, the Committee was mindful of the "public interest" test – a test that specifies that a tribunal or court should not depart from a jointly proposed penalty and costs order, unless the proposed order would bring the administration of justice into disrepute, or is otherwise contrary to the public interest. This has recently been affirmed by the Supreme Court of Canada in *R v. Anthony-Cook* 2016 SCC 43, and is a high hurdle to overcome.

The Committee also took into account a number of principles in assessing the adequacy of the proposed penalty. Paramount is the protection of the public. Also important is to express the abhorrence of the profession for the member's behaviour, and to maintain public confidence in the integrity of the profession and the College's ability to regulate the profession in the public interest. Deterrence, both of the member and other physicians, is also important in determining the penalty. When appropriate, the penalty should provide for rehabilitation of the member. The penalty should also be proportionate to the misconduct.

The Committee also considered aggravating and mitigating factors in this case and reviewed similar cases. Taking these factors and like cases into account, the Committee concluded that the jointly proposed order as to penalty and costs was appropriate.

Aggravating Factors

Practice deficiencies

Dr. Irwin has admitted to serious deficiencies in his clinical care, involving a significant number of patients. These deficiencies have placed patients at risk and have resulted in high levels of morbidity.

The College retained three experts – Dr. Faiz Daudi (2016), Dr. Jeffrey Shum (2015) and Dr. Reena Bhargava (2016) – to provide opinions on various aspects of care provided by Dr. Irwin. The reports of the experts were reviewed by the Committee. All expert opinions documented deficiencies in Dr. Irwin's clinical care.

Dr. Daudi found significant deficiencies in 12 of 36 patients' charts in Dr. Irwin's hospital practice (all deficiencies included patient safety issues). Deficiencies included the hasty ordering of surgery, a high incidence of incidental appendectomies and oophorectomies not in keeping with newer diagnostic techniques, prescribing of Demerol and antibiotics were not in keeping with current guidelines and use of mesh in a potentially contaminated field, reflecting either a knowledge deficit or a cavalier attitude towards patient care. His charting was poor. Many of the charts were incomplete. Some charts were missing consult notes, while others were missing operative and follow up notes. Operating notes at times lacked detail.

Dr. Shum reviewed Dr. Irwin's treatment of Patient A and opined that: Dr. Irwin had failed to adequately justify the need for colon and ovarian surgery; Dr. Irwin failed to disclose details of the pre-operative imaging to the patient; and failed to document adequately that he had informed, discussed and ensured that the patient had a reasonable understanding of the medical and surgical management.

As part of an out of hospital inspection program of the Reimer Clinic, Dr. Bhargava noted concerns regarding Dr. Irwin's competency at performing endoscopy. She reviewed 10 of Dr. Irwin's patient charts and observed two endoscopic cases. She opined that Dr. Irwin had failed to meet the standard of practice of the profession in his charting, documentation and organization, and in keeping up to date regarding current endoscopic guidelines.

Past History and Lack of Insight

The Committee was concerned with Dr. Irwin's repeated involvement with the College and his inability or unwillingness to make changes in his practice. Including the conduct that led to the findings in this case, the Committee noted multiple instances of Dr. Irwin's inadequate assessments, not obtaining or documenting appropriate consent for procedures and poor recordkeeping including dictating notes retroactively, after inspection.

Dr. Irwin was first cautioned by the Complaints Committee in 2005, regarding poor record keeping, involving an elderly patient and failing to document a complete clinical examination. It was noted that because the lesion was near the rectum, a rectal examination of a patient would have enabled further decisions regarding surgical treatments and patient consent. Dr. Irwin had not obtained and had not documented appropriate patient consent prior to proceeding with surgery.

Six years later, in January 2011, another complaint to the College about Dr. Irwin's patient care also involved a lack of consent – this time for a biopsy leading to excision of a mass. On this occasion, the patient complained that he had only consented to biopsies of a lesion in his neck and supraclavicular nodes. The ICRC found that there was a confusing clinical record, a lack of discussion about consent, and that a dictation of an operative note was done two months after the procedure and after the patient had complained to the College. The ICRC cautioned Dr. Irwin in writing on his process for obtaining and documenting consent, his documentation, and timely dictation of his clinical notes. He was also required to complete courses in Ethics and Consent, attend educational sessions with a preceptor, and undergo a practice reassessment.

A further complaint regarding Dr. Irwin's care was received in 2014 relating to an issue from 1999, which again involved clinical care of a surgical patient and management of a wound infection following surgery. The ICRC's decision of 2017 issued advice to Dr. Irwin regarding discharging a patient with a wound infection, fever and a high WBC.

In the spring of 2015, the College received a complaint from a patient regarding Dr. Irwin's surgical treatment for diverticulosis, which was followed by sepsis. The ICRC at that time was concerned about the documentation in the operating note and the consent discussion. There was also concern regarding excessive delay in having the patient return to the operating room when he began to experience complications. Again, the ICRC in its 2017 decision issued advice to Dr. Irwin to document thoroughly in the operating room note the details of consent discussion and ensure closer post-operative follow-up of high risk patients.

In relation to the timing of this latter complaint, the Committee noted that the review of the Medical Advisory Committee at the Cornwall Community Hospital (CCH) concluded in 2015, and its Board of Directors upheld that review in 2016. The results of their review were similar to the findings of the College's Committees, i.e., weak pre-operative workups and a low threshold for decisions with respect to surgical interventions; substandard record keeping; inappropriate use of antibiotics and mesh. It was noted that for protection of the public, a rigid structure of oversight was required but this was not possible at CCH and that an educational component of residency-type retraining was necessary for Dr. Irwin to practise surgery at the hospital.

Breach of the ICRC Order

In February and December 2017, the ICRC issued orders under section 37 of the Health Professions Procedural Code. These orders imposed terms, conditions and limitations on Dr. Irwin's certificate of registration, including restricting Dr. Irwin's practice to small surgical procedures and surgical consults, the requirement that a clinical supervisor conduct at monthly chart reviews of Dr. Irwin's patients, and the requirement that Dr.

Irwin advise the College of all his practice locations. Dr. Irwin breached the ICRC order by failing to report to the College that he had a home practice, involving visiting patients in their homes. Further, some treatment provided by Dr. Irwin both at his Akwesasne office and in the home visits exceeded the restriction on his scope of practice.

Practice Monitor's Reports

The Committee reviewed eight reports prepared by Dr. Irwin's practice monitor, Dr. Bruce Gay, from May 2017 to April 2018. The reports initially indicated very slow progress by Dr. Irwin in dealing with the deficiencies that had been noted over the previous decade. The early reports noted concerns with how consent was obtained, organization of clinical notes, and missing portions of notes. There were concerns regarding management of a patient with diarrhea, using steroids without a clear diagnosis and anal dilatation of a fissure. By late July 2017, Dr. Gay had observed a definite improvement in the organization of clinical records, but noted that 2 of 20 patient charts were hard to follow because of disorganization. Over the fall of 2017, Dr. Gay noted continued improvement but with occasional lapses: for example, the size and laxity of the skin in a patient having an excision for basal cell carcinoma was not recorded; and there was delay in completing several charts.

Of importance, Dr. Gay noted great improvements in the charts he reviewed in the first four months of 2018. He described the records: "overall the charts were excellent" having "an excellent description of risks"; and after January 2018, "all cases were within the scope of a general surgeon."

Mitigating factors

Dr. Irwin has admitted his professional misconduct and has expressed responsibility for his behaviour. By agreeing to the statement of facts and a joint submission on penalty, Dr. Irwin has saved the considerable time and cost of a contested hearing, and spared the witnesses from the significant emotional burden of having to testify at a hearing. His practice monitor has noted improvement since January 2018.

Case Law

While no two cases are exactly alike, it is useful to compare similar cases involving other physicians when determining the appropriateness of the penalty.

The Committee reviewed five cases filed that involved a breach of an undertaking or an order by a member, with accompanying deficiencies in the member's standards of care.

In *CPSO v. Nahri* (2015), the family physician had directly involved international medical graduates, who were not licensed physicians in Ontario, in the care of her patients. She inadequately supervised these individuals and did not delegate care to them appropriately. Dr. Nahri also breached an undertaking to document her review of the records of all patients who had received patient care directly from staff members. The Committee found that she failed to maintain the standard of practice of the profession and engaged in disgraceful, dishonourable or unprofessional conduct. The Committee ordered a six-month suspension, a reprimand and imposed terms, conditions and limitations on her certificate of registration, including the requirements for clinical supervision, an educational program, and an individualized ethics program. Dr. Nahri was also required to pay hearing costs to the College.

In *CPSO v. Aziz* (2014), the physician was an emergency medicine doctor, who was found to have failed to maintain the standard of practice of the profession in his care of a woman with chest pain, particularly with regard to an investigation, and in his record keeping with respect to another patient. The ICRC appointed an investigator into Dr. Aziz's emergency medicine practice. Dr. Aziz failed to respond to requests from the investigator and did not provide transcriptions of the charts that were required until after the allegations of professional misconduct were referred to the Discipline Committee. Dr. Aziz was therefore also found to have engaged in disgraceful dishonorable or unprofessional conduct for failing to cooperate with the investigation and for breach of an interim undertaking to the College. The Committee ordered a three-month suspension, a reprimand, and the imposition of terms, conditions and limitations on his certificate of

registration, including a period of supervision. Dr. Aziz was also required to pay hearing costs to the College.

CPSO v. Maytham (2011) involved a breach of an undertaking. Dr. Maytham had entered into an undertaking with the College, pursuant to which he agreed not to prescribe any controlled drugs until he had successfully completed the College's Prescribing Skills course and thereafter, to keep a narcotics register with respect to all controlled drugs or substances. Dr. Maytham breached the undertaking to adequately maintain the narcotics register. Dr. Maytham had multiple prior findings by the Discipline Committee. The Committee ordered a four month suspension and a reprimand. Dr. Maytham was also required to pay hearing costs.

In *CPSO v. Pyne* (2004), the physician was a general vascular and thoracic surgeon, who was found to have severe deficiencies in his clinical practice. He received notification from the Quality Assurance Committee that his practice put patients at risk and that he should cease seeing patients. He did remove himself from the on-call schedule and cancelled all of his surgeries. However, he continued to practise – seeing office patients, ordering tests, and conducting repeat visits. The Committee ordered a ten-month suspension, a reprimand and imposed terms, conditions and limitations on his certificate of registration. He was also required to pay costs.

In *CPSO v. Wu* (2009), Dr. Howard Wu, a family physician with an interest in the management of pain, had undertaken not to use nerve blocks in his practice. However, he breached this undertaking and performed thirty further nerve blocks on seven patients. The Committee ordered a six-month suspension, a reprimand and the imposition of terms, conditions and limitations on Dr. Wu's certificate of registration, including a prohibition from performing nerve blocks and a practice monitor for his chronic pain patients.

On reviewing these cases, the Discipline Committee concluded that the proposed penalty was within the range of similar, but not identical findings.

ORDER

The Committee stated its finding of professional misconduct and incompetence in paragraphs 1 and 2 of its written order of May 30, 2018. In that order, the Committee ordered and directed on the matter of penalty and costs that:

3. Dr. Irwin attend before the panel to be reprimanded.

4. the Registrar suspend Dr. Irwin's certificate of registration for a period of five (5) months commencing immediately.

5. the Registrar impose the following terms, conditions and limitations on Dr. Irwin's certificate of registration:
   (i) Dr. Irwin's practice is restricted to providing small surgical procedures requiring local anesthesia and surgical consultations.
   (ii) Dr. Irwin shall retain a College-approved clinical supervisor or supervisors (the "Clinical Supervisor"), who will sign an undertaking in the form attached as Appendix "A" [to the Order]. For a period of at least six (6) months commencing on the date Dr. Irwin returns to practice following the suspension of his certificate of registration, Dr. Irwin may practise only under the supervision of the Clinical Supervisor and will abide by all recommendations of his Clinical Supervisor with respect to his practice, including but not limited to practice improvements, practice management and continuing education. Clinical supervision of Dr. Irwin's practice may end after a minimum of six (6) months, only upon the recommendation of the Clinical Supervisor and, in its discretion, approval by the College. Clinical supervision of Dr. Irwin's practice shall contain the following elements:

      (a) The Clinical Supervisor will review a minimum of fifteen (15) of Dr. Irwin's patient charts every two (2) weeks, which shall be drawn from both his surgical procedures and surgical consultation areas of practice

if he has engaged in both areas of practice during the period under review, and any other practice area if he has expanded his scope of practice in accordance with paragraph 5(xii) of this Order; and

(b) The Clinical Supervisor will meet with Dr. Irwin in person a minimum of once a month and will report to the College every month, or more frequently if there is a risk of harm or other concerns.

(iii) The Clinical Supervisor will also facilitate the education program set out in the Individualized Education Plan ("IEP") in the form attached as Appendix "B" [to the Order].

(iv) If Dr. Irwin fails to retain a Clinical Supervisor as required above or if, prior to completion of Clinical Supervision, the Clinical Supervisor is unable or unwilling to continue in that role for any reason, Dr. Irwin shall within twenty (20) days retain a new College-approved Clinical Supervisor who will sign an undertaking in the form attached as Appendix "A" [to the Order], and if he has not been able to do so within twenty (20) days he shall cease to practise until the same has been delivered to the College.

(v) Approximately six (6) months after the completion of Clinical Supervision, Dr. Irwin shall undergo a reassessment of his practice (the "Reassessment") by a College-appointed assessor (the "Assessor"). The Reassessment may include a review of Dr. Irwin's patient charts, direct observations and interviews with staff and/or patients, and any other tools deemed necessary by the College. The Reassessment shall be at Dr. Irwin's expense and he shall co-operate with all elements of the Reassessment. Dr. Irwin shall abide by all recommendations made by the Assessor subject to paragraph 5(vi) below, and the results of the Reassessment will be reported to the College and may form the basis of further action by the College.

(vi) If Dr. Irwin is of the view that any of the Assessor's recommendations are unreasonable, he will have fifteen (15) days following his receipt of the recommendations within which to provide the College with his

submissions in this regard. The Inquiries Complaints and Reports ("ICR") Committee will consider those submissions and make a determination regarding whether the recommendations are reasonable, and that decision will be provided to Dr. Irwin. Following that decision Dr. Irwin will abide by those recommendations of the Assessor that the ICR Committee has determined are reasonable.

(vii) Dr. Irwin shall consent to sharing of information among the Assessor, the Clinical Supervisor and the College, as any of them deem necessary or desirable in order to fulfill their respective obligations.

(viii) Dr. Irwin shall inform the College of each and every location where he practises, in any jurisdiction (his "Practice Location(s)") within fifteen (15) days of this Order and shall inform the College of any and all new Practice Locations within fifteen (15) days of commencing practice at that location.

(ix) Dr. Irwin shall cooperate with unannounced inspections of his practice and patient charts by a College representative(s) for the purpose of monitoring and enforcing his compliance with the terms of this Order.

(x) Dr. Irwin shall consent to the College making appropriate enquiries of the Ontario Health Insurance Plan and/or any person who or institution that may have relevant information, in order for the College to monitor and enforce his compliance with the terms of this Order.

(xi) Dr. Irwin shall be responsible for any and all costs associated with implementing the terms of this Order.

(xii) If Dr. Irwin wishes to expand his scope of practice, including to engage in general surgical practice, general family medicine and/or palliative medicine, he will follow the College's Policy on Ensuring Competence: Changing Scope of Practice and/or Re-entering Practice, a copy of which is attached as Appendix "C" [to the Order], and must receive approval to expand his scope from the College in accordance with that policy.

6. Dr. Irwin pay to the College costs, in the amount of $10,180.00, in accordance with a payment plan approved by the College or, in the absence of such

a plan, within thirty (30) days of the date of this Order.

At the conclusion of the hearing, Dr. Irwin waived his right to an appeal under subsection 70(1) of the Code and the Committee administered the public reprimand.

TEXT of PUBLIC REPRIMAND

Delivered May 30, 2018

in the case of the

COLLEGE OF PHYSICIANS and SURGEONS of ONTARIO

and

DR. PAUL MAXWELL IRWIN

Dr. Irwin,

The Committee is, frankly, appalled that you find yourself before it, especially with the history of so many years of attempted remediation for your incompetence and failure to maintain the standard of practice in this province.

The practice of medicine is a privilege bestowed on us by the public, and they deserve the highest quality of care. It is imperative that a surgeon in this province can be trusted to be competent in their care and their record keeping. They must practise within the standard that is both published guidelines and also professional standards.

The Committee is concerned about your breach of the ICRC Order of December 2017, and we expect that you will respect this Committee and that you will follow today's Order strictly to the letter, and that there will be no further breaches. We trust that a significantly lengthy suspension of five months, followed by the continued limitations on your practice will express to you our disapproval and reinforce that the future inadequacies will not be tolerated.

We are aware of your practice monitor's recent positive reports, and we fully expect this to continue when you return to practice following your suspension.